		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033340

Facility Name: AVENUE CARE CENTER

Address: 4505 S. DREXEL (Number) CHICAGO (City) 60603 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3558590

Date of Initial License for Current Owners: 02/01/88

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,051	2,051	8
9	SNF/PED					9
10	ICF	50,212	473	330	51,015	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,212	473	2,381	53,066	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.80%

D. How many bed-hold days during this year were paid by Public Aid?
1,325 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started _____

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 2,051

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	131,341	30,054	9,091	170,486		170,486	2,411	172,897			1
2	Food Purchase		190,869		190,869	(17,739)	173,130	(866)	172,264			2
3	Housekeeping	118,055	50,844	0	168,899		168,899	0	168,899			3
4	Laundry	47,837	18,574	225	66,636		66,636	0	66,636			4
5	Heat and Other Utilities			120,976	120,976		120,976	607	121,583			5
6	Maintenance	36,460	34,116	33,868	104,444		104,444	11,800	116,244			6
7	Other (specify):*			8,278	8,278		8,278	0	8,278			7
8	**TOTAL General Services**	333,693	324,457	172,438	830,588	(17,739)	812,849	13,952	826,801			8
	B. Health Care and Programs											
9	Medical Director	0		5,500	5,500		5,500	0	5,500			9
10	Nursing and Medical Records	1,258,384	38,880	2,664	1,299,928		1,299,928	26,967	1,326,895			10
10a	Therapy	70,554	1,857	37,666	110,077		110,077	9,769	119,846			10a
11	Activities	75,529	8,694	2,333	86,556		86,556	0	86,556			11
12	Social Services	73,963		3,819	77,782		77,782	0	77,782			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			355	355		355	0	355			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,478,430	49,431	52,337	1,580,198	0	1,580,198	36,736	1,616,934			16
	C. General Administration											
17	Administrative	115,819		330,000	445,819		445,819	(274,612)	171,207			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			225,204	225,204		225,204	(174,120)	51,084			19
20	Dues, Fees, Subscriptions & Promotions			22,398	22,398		22,398	(2,494)	19,904			20
21	Clerical & General Office Expenses	39,363	8,415	137,101	184,879		184,879	(28,449)	156,430			21
22	Employee Benefits & Payroll Taxes			309,930	309,930	17,739	327,669	0	327,669			22
23	Inservice Training & Education			1,330	1,330		1,330	525	1,855			23
24	Travel and Seminar			0	0		0	553	553			24
25	Other Admin. Staff Transportation			222	222		222	2,522	2,744			25
26	Insurance-Prop.Liab.Malpractice			132,162	132,162		132,162	4,894	137,056			26
27	Other (specify):*			0	0		0	41,650	41,650			27
28	**TOTAL General Administration**	155,182	8,415	1,158,347	1,321,944	17,739	1,339,683	(429,531)	910,152			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,967,305	382,303	1,383,122	3,732,730	0	3,732,730	(378,843)	3,353,887			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number AVENUE CARE CENTER #0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,152	33,152		33,152	131,099	164,251			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			(57,835)	(57,835)		(57,835)	412,479	354,644			32
33	Real Estate Taxes			166,817	166,817		166,817	0	166,817			33
34	Rent-Facility & Grounds			531,289	531,289		531,289	(524,179)	7,110			34
35	Rent-Equipment & Vehicles			33,244	33,244		33,244	(7,219)	26,025			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			706,667	706,667	0	706,667	12,180	718,847			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		25,058	76,056	101,114		101,114	(13,149)	87,965			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			84,863	84,863		84,863	0	84,863			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	25,058	160,919	185,977	0	185,977	(13,149)	172,828			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,967,305	407,361	2,250,708	4,625,374	0	4,625,374	(379,812)	4,245,562			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	599	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(866)	2		13
14	Non-Care Related Interest	(18,763)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(50)	20		17
18	Fines and Penalties	(18,048)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,577)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(3,288)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,370)	20		28
29	Other-Attach Schedule SEE PAGE 5A	0			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,363)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(335,449)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (335,449)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (379,812)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

AVENUE CARE CENTER

ID# 0033340

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVENUE CARE CENTER # 0033340 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	2,411	0	0	0	0	0	0	0	0	0	2,411	1
2	Food Purchase	(866)	0	0	0	0	0	0	0	0	0	0	(866)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	607	0	0	0	0	0	0	0	0	0	607	5
6	Maintenance	0	11,800	0	0	0	0	0	0	0	0	0	11,800	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(866)	14,818	0	0	0	0	0	0	0	0	0	13,952	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	26,967	0	0	0	0	0	0	0	0	0	26,967	10
10a	Therapy	0	10,654	0	(885)	0	0	0	0	0	0	0	9,769	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	37,621	0	(885)	0	0	0	0	0	0	0	36,736	16
	C. General Administration													
17	Administrative	0	(330,000)	55,388	0	0	0	0	0	0	0	0	(274,612)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(180,000)	5,880	0	0	0	0	0	0	0	0	(174,120)	19
20	Fees, Subscriptions & Promotions	(7,285)	0	4,791	0	0	0	0	0	0	0	0	(2,494)	20
21	Clerical & General Office Expenses	(18,048)	(93,000)	82,599	0	0	0	0	0	0	0	0	(28,449)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	525	0	0	0	0	0	0	0	0	525	23
24	Travel and Seminar	0	0	553	0	0	0	0	0	0	0	0	553	24
25	Other Admin. Staff Transportation	0	0	2,522	0	0	0	0	0	0	0	0	2,522	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,894	0	0	0	0	0	0	0	0	4,894	26
27	Other (specify):*	0	0	41,650	0	0	0	0	0	0	0	0	41,650	27
28	**TOTAL General Administration**	(25,333)	(603,000)	198,802	0	0	0	0	0	0	0	0	(429,531)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,199)	(550,561)	198,802	(885)	0	0	0	0	0	0	0	(378,843)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number AVENUE CARE CENTER **#** 0033340 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	599	0	130,500	0	0	0	0	0	0	0	0	131,099	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,763)	0	431,242	0	0	0	0	0	0	0	0	412,479	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(524,179)	0	0	0	0	0	0	0	0	(524,179)	34
35	Rent-Equipment & Vehicles	0	(14,784)	7,565	0	0	0	0	0	0	0	0	(7,219)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,164)	(14,784)	45,128	0	0	0	0	0	0	0	0	12,180	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(13,149)	0	0	0	0	0	0	0	(13,149)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(13,149)	0	0	0	0	0	0	0	(13,149)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(44,363)	(565,345)	243,930	(14,034)	0	0	0	0	0	0	0	(379,812)	45

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
SEE ATTACHED SCHEDULE				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				AVENUE ASSOC.		
				LLC	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 330,000			$	$ (330,000)	1
2	V	19	ADMIN. CONSULTANT FEES	168,000				(168,000)	2
3	V	19	DATA PROCESSING FEES	12,000				(12,000)	3
4	V	21	CLERICAL FEES	93,000				(93,000)	4
5	V	1	DIETARY CONSULTANT FEES	6,600				(6,600)	5
6	V	35	COMPUTER LEASE	14,784				(14,784)	6
7	V	1	DIETARY SALARIES		CAREPLUS MANAGEMENT, INC.		9,011	9,011	7
8	V	5	ELECTRICITY		" "		607	607	8
9	V	6	MAIN & REPAIRS		" "		346	346	9
10	V	6	MAINTENANCE SALARIES		" "		11,454	11,454	10
11	V	10	NURSING SALARIES		" "		26,967	26,967	11
12	V	10a	THERAPY SUPPLIES/SERVICES		" "		1,458	1,458	12
13	V	10a	THERAPY SALARIES		" "		9,196	9,196	13
14	Total			$ 624,384			$ 59,039	$ * (565,345)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 531,289	AVENUE ASSOCIATES LLC		$	$ (531,289)	15
16	V	30	SL DEPRECIATION				119,246	119,246	16
17	V	32	INTEREST				412,479	412,479	17
18	V								18
19	V								19
20	V	17	ADMIN SALARIES		CAREPLUS MGMT INC		55,388	55,388	20
21	V	19	PROFESSIONAL FEES		" "		5,880	5,880	21
22	V	20	ADVERTISING		" "		4,791	4,791	22
23	V	21	TOTAL OFFICE		" "		21,861	21,861	23
24	V	21	CLERICAL SALARIES		" "		60,738	60,738	24
25	V	23	SEMINARS		" "		525	525	25
26	V	24	TRAVEL		" "		553	553	26
27	V	25	TRANSPORTATION		" "		2,522	2,522	27
28	V	26	INSURANCE		" "		4,894	4,894	28
29	V	27	EMPLOYEE BENEFITS		" "		41,650	41,650	29
30	V	30	DEPRECIATION (SL)		" "		11,254	11,254	30
31	V	32	INTEREST		" "		18,763	18,763	31
32	V	34	OFFICE RENT		" "		7,110	7,110	32
33	V	35	EQUIP RENT/AUTO LEASE		" "		7,565	7,565	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 531,289			$ 775,219	$ * 243,930	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 37,665	CAREPLUS REHABILITATIVE SERVICES		$ 36,780	$ (885)	15
16	V	39	ANCILLARY THERAPY	76,055			62,906	(13,149)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 113,720			$ 99,686	$ * (14,034)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRATIV	19.70	SEE ATTACHED	5.4	8.97	SALARY	16,594	17-7	2
3			FINANCE		SCHEDULES						3
4			BANKING								4
5											5
6	ROSLYN INDICH	CLERICAL	CLERICAL	10.25		5.4	8.97	SALARY	4,043	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,637		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	606,625	15	$ 83,890	$ 83,890	54,413	$ 9,011	1
2	5	ELECTRICITY	CENSUS DAYS	606,625	15	6,767		54,413	607	2
3	6	MAIN & REPAIRS	CENSUS DAYS	606,625	15	3,858		54,413	346	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	606,625	15	127,691	127,691	54,413	11,454	4
5	10	NURSING SALARIES	CENSUS DAYS	606,625	15	300,646	300,646	54,413	26,967	5
6	10a	THERAPY SUPPLIES/SERVICE	CENSUS DAYS	606,625	15	15,283		54,413	1,458	6
7	10a	THERAPY SALARIES	CENSUS DAYS	606,625	15	96,375	96,375	54,413	9,196	7
8	17	ADMIN SALARIES	CENSUS DAYS	606,625	15	617,499	617,499	54,413	55,388	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	606,625	15	65,550		54,413	5,880	9
10	20	ADVERTISING	CENSUS DAYS	606,625	15	53,408		54,413	4,791	10
11	21	TOTAL OFFICE	CENSUS DAYS	606,625	15	243,714		54,413	21,861	11
12	21	CLERICAL SALARIES	CENSUS DAYS	606,625	15	677,141	677,141	54,413	60,738	12
13	23	SEMINARS	CENSUS DAYS	606,625	15	5,849		54,413	525	13
14	24	TRAVEL	CENSUS DAYS	606,625	15	6,170		54,413	553	14
15	25	TRANSPORTATION	CENSUS DAYS	606,625	15	28,114		54,413	2,522	15
16	26	INSURANCE	CENSUS DAYS	606,625	15	54,564		54,413	4,894	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	606,625	15	464,335		54,413	41,650	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	606,625	15	125,471		54,413	11,254	18
19	32	INTEREST	CENSUS DAYS	606,625	15	209,175		54,413	18,763	19
20	34	OFFICE RENT	CENSUS DAYS	606,625	15	79,265		54,413	7,110	20
21	35	EQUIP RENT/AUTO LEASE	CENSUS DAYS	606,625	15	84,343		54,413	7,565	21
22										22
23										23
24										24
25	TOTALS					$ 3,349,108	$ 1,903,242		$ 302,533	25

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AVENUE ASSOCIATES, LLC
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	SL DEPRECIATION	DIRECT COST	1	1	$ 119,246	$	1	$ 119,246	1
2	32	INTEREST	DIRECT COST	1	1	412,479		1	412,479	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 531,725	$		$ 531,725	25

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: AVENUE ASSOCIATES LLC						$	$			$	1
2	PACIFIC MUTUAL		X	MORTGAGE	$38,703.00	12/95	4,657,452	4,256,354	01/08	0.0888	381,984	2
3	LOAN COST		X	LOAN COST	W/O OVER 12	YEARS	118,077	58,269	01/08		9,840	3
4	CIB BANK		X	CAPITAL IMPROVEMENTS	$6,635.09	02/01	315,000	269,041	02/06	PRIME+	20,392	4
5	LOAN COST		X	LOAN COST	W/O OVER 5 YEARS		1,575	1,316	02/06		263	5
	Working Capital											
6	CAREPLUS MGMT INC.	X		WORKING CAPITAL	DEMAND		750,000	(1,525,000)		PRIME+	(61,330)	6
7	FIRST PREMIUM		X	INSURANCE FINANCING							3,495	7
8												8
9	TOTAL Facility Related				$45,338.09		$ 5,842,104	$ 3,059,980			$ 354,644	9
	B. Non-Facility Related*											
10	CAREPLUS MANAGEMENT ALLOCATION										18,763	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 18,763	14
15	TOTALS (line 9+line14)						$ 5,842,104	$ 3,059,980			$ 373,407	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 159,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 162,147	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,047	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 163,770	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 166,817	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	112,016	8
	1997	155,823	9
	1998	158,589	10
	1999	157,524	11
	2000	162,147	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AVENUE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0033340

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-02-312-001-0000	NURSING HOME	$ 162,146.94	$ 162,146.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 162,146.94	$ 162,146.94

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 0 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,736	1995	$ 100,000	1
2					2
3	TOTALS	51,736		$ 100,000	3

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	155		1995	1971	4,046,250	103,746	39	103,746		713,395	5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER SYSTEM			1988	5,400	171	25	216	45	2,934	9
10	LEASEHOLD IMPROVEMENTS			1989	1,035	33	20	52	19	624	10
11	LEASEHOLD IMPROVEMENTS			1990	5,400	171	20	270	99	3,127	11
12	LEASEHOLD IMPROVEMENTS			1991	14,414	457	20	721	264	7,571	12
13	LEASEHOLD IMPROVEMENTS			1992	42,003	1,384	31.5	1,333	(51)	12,989	13
14	LEASEHOLD IMPROVEMENTS			1993	16,403	433	31.5	521	88	4,428	14
15	LEASEHOLD IMPROVEMENTS			1993	1,081	72	15	72		612	15
16	LEASEHOLD IMPROVEMENTS			1994	15,686	402	39	402		3,083	16
17	LEASEHOLD IMPROVEMENTS			1994	9,604	427	20	480	53	3,600	17
18	ELEVATOR REPAIR & DOOR			1995	44,614	1,144	39	1,144		7,198	18
19	PAVING			1995	3,600	240	15	240		1,560	19
20	ALARM SYSTEM			1996	1,820	47	39	47		268	20
21	PLUMBING			1996	2,737	70	39	70		394	21
22	WALK-IN COOLER			1996	9,998	256	39	256		1,351	22
23	DOORS AND ROOF REPAIR			1997	5,110	131	39	131		635	23
24	FENCE			1997	19,800	508	39	508		2,307	24
25	FLOORING/BUMPER GUARDRAILS/HANDRAILS			1997	30,579	785	39	784	(1)	3,444	25
26	BUILT-IN NURSES' STATION & WARDROBES			1997	26,176	671	39	671		3,021	26
27	SMOKE & FIRE DAMPERS			1998	7,100	182	39	182		583	27
28	ELEVATOR REPAIR AND LAUNDRY ROOM ELECTRICAL/CIRCU			1998	5,931	152	39	152		554	28
29	PARKING LOT PAVING AND LANDSCAPING			1998	53,109	3,542	15	3,541	(1)	12,392	29
30	FLOORING			1998	11,516	295	39	295		1,021	30
31	FIRE SAFETY UPGRADE/LIGHTING/EXHAUST/ROOF			1999	57,028	1,462	39	1,462		3,715	31
32	ONE SUMP PUMP ASSEMBLY			2000	4,200	153	27.5	153		172	32
33	RELOCATION OF A/C UNIT			2000	3,015	110	27.5	110		124	33
34	INSTALL PULL STATION & REWIRE BLDG			2000	5,878	214	27.5	214		241	34
35	CONCRETE STAIRS & RAMP REPLACEMENT			2001	20,000	394	27.5	394		394	35
36	REPLACEMENT CARPET-1ST FLOOR			2001	2,422	484	20	121	(363)	121	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LANDSCAPE INSTALLATION	2001	$ 2,910	$ 194	15	$ 194	$	$ 194	37
38	REPAIR PASSENGER & SMALL SERVICE ELEVATORS	2001	11,654	124	27.5	124		124	38
39	DECK	2001	12,170	811	15	811		811	39
40	SECOND FLOOR RESIDENT ROOMS-CLOSETS	2001	26,075	198	27.5	198		198	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50	CAREPLUS MANAGEMENT INC:								50
51	LESEHOLD IMPROVEMENTS			106		106			51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,524,718	$ 119,569		$ 119,721	$ 152	$ 793,185	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 181,150	$ 14,894	$ 16,589	$ 1,695		$ 95,399	71
72	Current Year Purchases	12,705	2,541	1,293	(1,248)		1,293	72
73	Fully Depreciated Assets	17,916			0		17,916	73
74	RELATED PARTY -ALLOC SL DEPR		26,648	26,648	0			74
75	TOTALS	$ 211,771	$ 44,083	$ 44,530	$ 447		$ 114,608	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,836,489	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 163,652	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 164,251	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 599	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 907,793	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 33,244 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 26,002	$		$ 26,002	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			50,054			50,054	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				17,058		17,058	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LABS/RENTALS	39-2 39-2					7,408 592		7,408 592	13
14	TOTAL			$		$ 76,056	$ 25,058		$ 101,114	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number AVENUE CARE CENTER **#** 0033340 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (148,219)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,201,300		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,067		6
7	Other Prepaid Expenses	1,731		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(29,679)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,068,200	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	468,864		15
16	Equipment, at Historical Cost	221,375		16
17	Accumulated Depreciation (book methods)	(252,105)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	96,804		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DUE FROM AVENUE LLC	122,361		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 657,299	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,725,499	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 327,344	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	355		28
29	Short-Term Notes Payable	(1,483,659)		29
30	Accrued Salaries Payable	76,039		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,957		31
32	Accrued Real Estate Taxes(Sch.IX-B)	163,770		32
33	Accrued Interest Payable	(1,115)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,778		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (896,531)	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (896,531)	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,622,030	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,725,499	$ 0	48

***(See instructions.)**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,547,011	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(9,435)	3
4	PRIOR YEAR ADJUSTMENT	(13,903)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,523,673	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,098,357	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,098,357	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,622,030	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,715,814	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,715,814	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	6,707	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,707	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,723,731	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	830,588	31
32	Health Care	1,580,198	32
33	General Administration	1,321,944	33
	B. Capital Expense		
34	Ownership	706,667	34
	C. Ancillary Expense		
35	Special Cost Centers	101,114	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,625,374	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,098,357	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,098,357	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX RETURN NOT YET PREPARED**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,923	2,232	$ 69,289	$ 31.04	1
2	Assistant Director of Nursing	2,022	2,143	54,951	25.64	2
3	Registered Nurses	6,425	7,782	162,171	20.84	3
4	Licensed Practical Nurses	22,899	23,748	376,165	15.84	4
5	Nurse Aides & Orderlies	69,839	75,636	582,394	7.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,947	8,359	70,554	8.44	8
9	Activity Director					9
10	Activity Assistants	10,811	11,026	75,529	6.85	10
11	Social Service Workers	4,572	4,837	73,963	15.29	11
12	Dietician					12
13	Food Service Supervisor	1,104	1,144	12,584	11.00	13
14	Head Cook	6,686	6,914	42,812	6.19	14
15	Cook Helpers/Assistants	12,608	13,277	75,945	5.72	15
16	Dishwashers					16
17	Maintenance Workers	3,869	4,078	36,460	8.94	17
18	Housekeepers	19,465	20,711	118,055	5.70	18
19	Laundry	6,268	6,738	47,837	7.10	19
20	Administrator	1,977	2,120	75,782	35.75	20
21	Assistant Administrator	1,864	2,038	40,037	19.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,531	3,559	39,363	11.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,702	1,751	13,414	7.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,512	198,093	$ 1,967,305 *	$ 9.93	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,600	1-3	35
36	Medical Director	O	5,500	9-3	36
37	Medical Records Consultant	N	2,064	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	2,333	11-3	44
45	Social Service Consultant	E	3,819	12-3	45
46	Other(specify)	E			46
47		S			47
48					48
49	TOTAL (lines 35 - 48)		$ 31,716		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GLORIA GREEN	ADMIN		$ 75,782
	ASST ADMIN		40,037
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,819

B. Administrative - Other

Description	Amount
CAREPLUS MANAGEMENT - MANAGEMENT FEES	$ 330,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 330,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CARE PLUS	DATA PROCESSING	$ 12,000
AMERICAN DATA	DATA PROCESSING	1,800
HDSI	DATA PROCESSING	1,239
CARE PLUS	ADMIN. CONSULTANT	168,000
KRUPNICK,BOKOR, KAGDA	ACCOUNTING FEES	30,300
MEYER MAGENCE	LEGAL FEES	3,953
ART ROUSEAU	LEGAL FEES	125
WINSTON & STRAWN	LEGAL FEES	975
ECONOCARE	PURCHASE CONSULT	1,627
PERSONNEL PLANNERS	UC CONSULT	1,435
RICHARD PEELO	MEDICARE CONSULT	3,750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 225,204

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,041
Unemployment Compensation Insurance	25,619
FICA Taxes	149,962
Employee Health Insurance	73,900
Employee Meals	17,739
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,634
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	25,818
CHICAGO HEAD TAX	3,956
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 327,669

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,334
Health Care Worker Background Check	30
(Indicate # of checks performed 3)	
MARKETING/ADV/PROMO	4,658
TRUST FEES/CONTRIBUTIONS	2,627
MGMT CO ALLOCATION	4,791
DUES & SUBSCRIPTIONS	5,875
LICENSES & PERMITS	2,874
TRUST FEES/CONTRIBUTIONS	(2,627)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,288)
Yellow page advertising	(1,370)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,904

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	553
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 553

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $4875**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **84,863**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,739** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: AVENUE CARE CENTER **#0033340** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,600	
	REPAIRS & MAINTENANCE		2,491	
			0	9,091
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		225	
			0	225
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		54,412	
	ELECTRICITY		43,849	
	WATER		21,251	
	CABLE TV - LOBBY		1,464	
			0	120,976
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		150	
	PAINTING & DECORATING		1,024	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,281	
	ELEVATOR MAINTENANCE & REPAIR		16,959	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,400	
	FIRE SERVICE		4,054	
			0	
			0	
			0	33,868
7	**OTHER**			
	SCAVENGER		8,278	
	SECURITY SERVICE		0	8,278
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,064	
	PHARMACY CONSULTANT	XVIII B 39-2	600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	2,664
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		9,432	
	THERAPY CONTRACT SERVICES		10,265	
	OCCUPATIONAL THERAPY SERVICES		7,169	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	37,666
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,333	
			0	2,333
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,819	
			0	3,819
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AVENUE CARE CENTER **#0033340** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		355	355
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	330,000	330,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,039	
	ADMINISTRATIVE CONSULTANTS	XIX C	168,000	
	PROFESSIONAL FEES	XIX C	42,165	
			0	225,204
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,288	
	EMPLOYEE WANT ADS	XIX F	6,334	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	5,875	
	LICENSES & PERMITS	XIX F	2,874	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,370	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	50	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,077	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	30	22,398
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES			
	EQUIPMENT REPAIR & MAINTENANCE		5,858	
	OUTSIDE CLERICAL SERVICES		93,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	18,048	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,343	
	TELEPHONE		18,134	
	MESSENGER SERVICE		718	
			0	137,101

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	149,962	
	UNEMPLOYMENT COMPENSATION	XIX D	25,619	
	WORKERS COMPENSATION INSURANC	XIX D	28,041	
	HOSPITALIZATION INSURANCE	XIX D	73,900	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,634	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	UNION PENSION FUND/401 K EXPENSE	XIX D	25,818	
	CHICAGO HEAD TAX	XIX D	3,956	309,930
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,330	1,330
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G		
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		222	222
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		132,162	132,162
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,383,122

AVENUE CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	190,869
LESS SALES TAX	(866)
NET FOOD	190,003
TOTAL PATIENT CENSUS	53,066
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	159198
ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	16425

PATIENT MEALS	159198
ADD EMPLOYEE MEALS	16425
TOTAL MEALS/YEAR	175623
NET FOOD	190003
DIVIDE TOTAL MEALS/YEAR	175623
COST PER MEAL	1.08
TIME EMPLOYEE MEALS	16425
EMPLOYEE MEAL RECLASSIFICATION	17739